

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL016018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARTERET HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3020 MARKET STREET NEWPORT, NC 28570</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments  This is a Report of a Biennial Survey conducted by Greg Cates and Frank Strickland on March 15, 2016.  Based on information gathered from our files, the Facility was first licensed on 16, 1994 for Sixty (60) Beds. Based on this information, the facility is required to meet the 1991 Minimum and Desired Standards and Regulations for the Licensing of Adult Care Homes; applicable portions of the 2005 Licensing of Adult Care Homes of Seven or More Beds; and the 1991 North Carolina State Building Code, Section 514.1- Institutional (I) Occupancy- Unrestrained.	C 000		
C 164	Housekeeping and Furnishings-Clean, Repaired  SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; (2) have no chronic unpleasant odors; (3) have furniture clean and in good repair; (e) This Rule shall apply to new and existing facilities.  This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to maintain the building and furnishings clean and in good repair.  Findings include:  a- The paint on the front drive-thru canopy is worn and the drywall mud joints are visible. b- The drive-thru canopy columns are	C 164		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL016018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARTERET HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3020 MARKET STREET NEWPORT, NC 28570</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 164	Continued From page 1  showing signs of rot at the base. c- The front porch ceilings and porch rails have worn and peeling paint. d- The front left corner fascia board has been chewed open by an animal, and there is a large hole leading into the attic space e- In the Residential Laundry, a past roof leak has led to the wall paint peeling on the back wall. f- In the Residential Laundry, there is a paint patch that is a much darker color than the original wall color. g- In the Soiled Utility Room beside the Staff Breakroom, a past roof leak has led to the paint peeling from the ceiling around the fluorescent light fixture.	C 164		
C 166	Housekeeping-Maintained Free of Hazards  SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; (e) This Rule shall apply to new and existing facilities.  This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to maintain the building free of hazards by not storing oxygen containers securely to prevent them from falling over or rolling around. This could affect all persons in the facility as the oxygen containers could fall over, damaging the cylinder or nozzle.  Findings include:	C 166		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL016018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARTERET HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3020 MARKET STREET NEWPORT, NC 28570</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 166	Continued From page 2  a- In the Oxygen Storage Room, there are 5 oxygen bottles that are not properly supported. .	C 166		
C 189	Building Equipment Maintained Safe, Operating  SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.  This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to maintain the doors so that they operate correctly and close and latch.  Findings include:  a- The door to the bathroom in the Kitchen rubs against the frame and will not close and latch.  2- Based on observations, the facility has failed to maintain the building electrical system safe and operating. This deficiency may affect those persons using the receptacles by allowing the possibility of electrical shock.  Findings include:	C 189		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL016018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARTERET HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3020 MARKET STREET NEWPORT, NC 28570</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 189	Continued From page 3  a- The GFCI receptacle located to the left of the Beauty Shop sinks does not trip when tested.  3- Based on observations, the facility has failed to maintain the plumbing systems safe by allowing the possibility of bacteria migrating into the ice machine. This may affect any person in the facility who uses the ice from the ice machine.  Finding include:  a- The drain pipe from the ice machine does not have a 2 inch air gap between the drain pipe and the floor drain.	C 189		
C 199	Exhaust Ventilation  SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.  This Rule is not met as evidenced by: 1- Based on observations and testing, the facility has failed to provide a mechanical exhaust in all	C 199		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL016018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARTERET HOUSE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3020 MARKET STREET NEWPORT, NC 28570</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 199	Continued From page 4  required areas. This may affect all persons in the building as it prevents the exhausting of odors and possible bacteria or germs that may cause illness.  Findings include:  a- The exhaust fan in the Chemical Storage Room of the Laundry Room is not pulling air. b- The exhaust fan in the Housekeeping/ Soiled Linen Room is not pulling air.	C 199		